

UNITED STATES DEPARTMENT OF THE INTERIOR  
MINERALS MANAGEMENT SERVICE  
GULF OF MEXICO REGION  
**ACCIDENT INVESTIGATION REPORT**

1. OCCURRED

DATE: **02-OCT-2008** TIME: **1350** HOURS

2. OPERATOR: **Tarpon Operating & Development, L**  
REPRESENTATIVE: **Rachal, Erin**  
TELEPHONE: **(281) 578-3388**  
CONTRACTOR: **Pioneer Contract Services**  
REPRESENTATIVE: **Steve Sparks**  
TELEPHONE: **(337) 233-3089**

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR  
ON SITE AT TIME OF INCIDENT:

4. LEASE: **G16224**  
AREA: **WC** LATITUDE:  
BLOCK: **661** LONGITUDE:

5. PLATFORM: **A**  
RIG NAME:

6. ACTIVITY: ☐ EXPLORATION (POE)  
☒ DEVELOPMENT/PRODUCTION  
(DOCD/POD)

7. TYPE:

☐ HISTORIC INJURY  
☐ REQUIRED EVACUATION  
☐ LTA (1-3 days)  
☒ LTA (>3 days) **1**  
☐ RW/JT (1-3 days)  
☐ RW/JT (>3 days)  
☐ Other Injury

☐ FATALITY  
☐ POLLUTION  
☐ FIRE  
☐ EXPLOSION

LWC ☐ HISTORIC BLOWOUT  
☐ UNDERGROUND  
☐ SURFACE  
☐ DEVERTER  
☐ SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION ☐ HISTORIC ☐ >\$25K ☐ <=\$25K

☐ STRUCTURAL DAMAGE  
☐ CRANE  
☒ OTHER LIFTING DEVICE **Air Hoist (Tugger)**  
☐ DAMAGED/DISABLED SAFETY SYS.  
☐ INCIDENT >\$25K  
☐ H2S/15MIN./20PPM  
☐ REQUIRED MUSTER  
☐ SHUTDOWN FROM GAS RELEASE  
☐ OTHER

6. OPERATION:

☐ PRODUCTION  
☐ DRILLING  
☐ WORKOVER  
☐ COMPLETION  
☐ HELICOPTER  
☐ MOTOR VESSEL  
☐ PIPELINE SEGMENT NO.  
☒ OTHER **Construction Operations**

8. CAUSE:

☐ EQUIPMENT FAILURE  
☒ HUMAN ERROR  
☐ EXTERNAL DAMAGE  
☐ SLIP/TRIP/FALL  
☐ WEATHER RELATED  
☐ LEAK  
☐ UPSET H2O TREATING  
☐ OVERBOARD DRILLING FLUID  
☐ OTHER \_\_\_\_\_

9. WATER DEPTH: **484** FT.

10. DISTANCE FROM SHORE: **120** MI.

11. WIND DIRECTION: **NE**  
SPEED: **5** M.P.H.

12. CURRENT DIRECTION:  
SPEED: M.P.H.

13. SEA STATE: FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On Wednesday 1 October 2008 Hurricane Ike damages were being repaired to a staircase and 40 feet of walkway from the cellar deck to the sump deck on Tarpon's WC-661-A Platform. Crews were being utilized from Southland Fabrication and Offshore & Pioneer Contract Services. A replacement prefabricated staircase and walkway "catwalk" were delivered to the platform by boat, with the crews setting-up three (3) air hoists (tuggers) to vertically lift the 40 feet of walkway from the boat to the platform. Two of the air tuggers had been welded to the platform, and the third air tugger was set down on the platform deck, wedged between the glymine skid and the separator skid, without being welding to the deck. The crews lifted the catwalk from the boat using the three air tuggers, then tack welded the catwalk in place prior to shutting down for the evening. The job resumed the next morning between 0530-0600 hours with the production and construction crew members attending a safety meeting. During the safety meeting they completed a Job Safety Analysis (JSA) for the catwalk installation that had not been completed the day before. Subsequent to the JSA meeting, the crews completed the catwalk installation between 1100-1130 hours, and then took a lunch break. Subsequent to lunch, at approximately 1145-1200 hours, three (3) riggers were set on the boat to attach slings to the staircase and then the staircase was lifted by the Crane Operator to make sure the load was centered prior to setting the load back down on the boat. The boat was then repositioned around to the south side of the platform where the staircase was lifted with one air tugger since the crane was unable to reach this area of the platform. The air tugger, welded to the deck with a cable running through a snatch block attached to a lifting davit (stinger), was used to make the lift from the boat to the platform. Once the staircase was successfully lifted to the top of the cellar deck, the staircase would not align with the catwalk. The crew members then unsuccessfully utilized a chain hoist and come-along to assist with aligning the staircase with the catwalk. The Construction Foreman then made the decision to utilize the unsecured (non-welded) air tugger to assist the crews in aligning the staircase with the catwalk. The crews attached the unsecured tugger's cable to the staircase and the Construction Foreman signaled the Tugger Operator to "winch up" on the tugger control in an effort to move the staircase into position. After several attempts were made to align the staircase with the catwalk, the tugger unexpectedly shifted towards the load (staircase) and crushed the Tugger Operator's hand between the air tugger and a two inch (2") pipe on the glymine skid. The Tugger Operator informed the Construction Foreman of the incident and first aid was immediately administered until a helicopter arrived to transport the Operator for medical treatment. The Operator continues to remain on medical leave and is not scheduled to return until after the Operator's next physician visit scheduled in January 2009.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

The air hoist (tugger), not welded to the platform deck, shifted under load crushing the Tugger Operator's hand between the tugger and a 2" pipe on the glymine unit skid.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

\* Failure to follow Standard Operating Procedures (SOP) for tugger operations when the

decision was made to utilize the tugger without being secured (welded) to the deck.  
\* Failure to perform an initial JSA for the task at hand allowed critical safety hazards to be overlooked.

20. LIST THE ADDITIONAL INFORMATION:

21. PROPERTY DAMAGED:

**None**

NATURE OF DAMAGE:

**N/A**

ESTIMATED AMOUNT (TOTAL):

**\$**

22. RECOMMENDATIONS TO PREVENT RECURRENCE NARRATIVE:

**The Lake Charles District does not have any recommendations for the MMS Regional Office of Safety Management (OSM).**

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **YES**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

**G110-C Unsafe air hoist (tugger) operations. Construction personnel failed to secure the tugger to the deck before commencing operations.**

25. DATE OF ONSITE INVESTIGATION:

**29-OCT-2008**

26. ONSITE TEAM MEMBERS:

**Wayne Meaux / Scott Mouton / Cody  
LeBlanc /**

29. ACCIDENT INVESTIGATION

PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

**Larry Williamson**

APPROVED

DATE: **19-DEC-2008**

# INJURY/FATALITY/WITNESS ATTACHMENT

☐ OPERATOR REPRESENTATIVE

☒ INJURY

☐ CONTRACTOR REPRESENTATIVE

☐ FATALITY

☒ OTHER Construction Roustabout

☐ WITNESS

NAME:

HOME ADDRESS:

CITY:

STATE:

WORK PHONE:

TOTAL OFFSHORE EXPERIENCE:

YEARS

EMPLOYED BY:

BUSINESS ADDRESS:

CITY:

STATE:

ZIP CODE: